

Medicaid's Crucial Role in Combating the Maternal Mortality and Morbidity Crisis

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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Welcome

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About Manatt Health

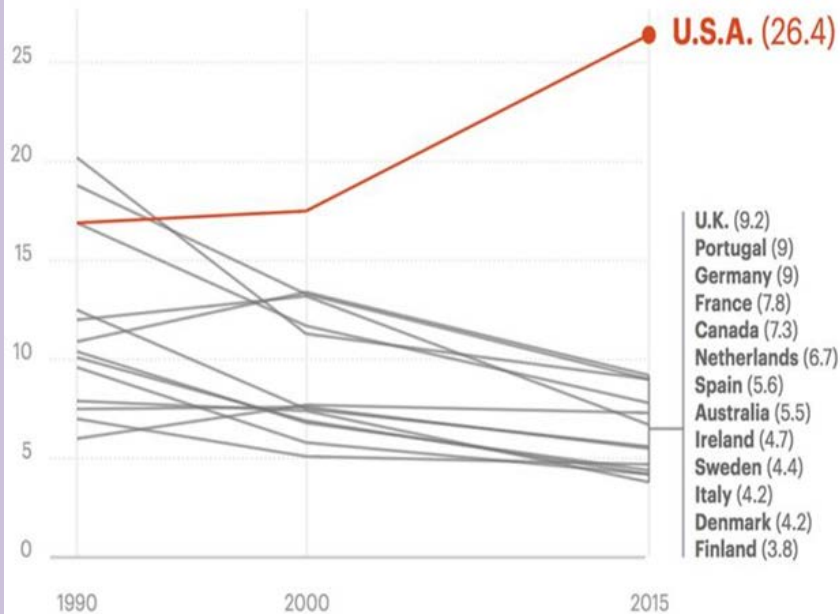
Patricia Boozang, Chiquita Brooks-LaSure, Gayle Mauser, and Michelle Howell prepared this presentation. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 90 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Agenda

- Maternal Mortality and Morbidity: A Public Health Crisis
- Medicaid's Pivotal Role in Improving Outcomes and Overcoming Disparities
- Medicaid Strategies

The Public Health Crisis

Deaths Per 100,000 Live Births in the U.S. vs. Other Developed Countries (1990, 2000, 2015)¹



Source: *The Lancet*

- **Black and American Indian/Alaska Native women are more likely to die from pregnancy-related causes²**
 - Black women: 3.3x more likely
 - American Indian/Alaska Native women: 2.5x more likely
- **~60% of pregnancy-related deaths are preventable**

For every death, another 70 women suffer from severe maternal morbidity.³

Medicaid's Pivotal Role

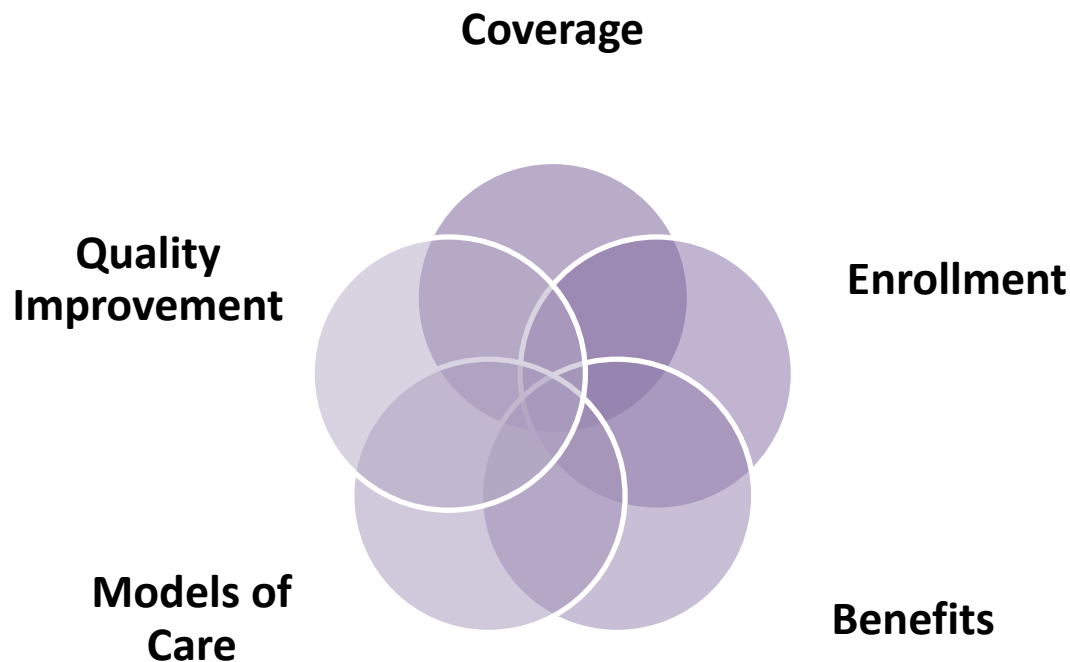
Medicaid is Uniquely Positioned to Improve Outcomes and Disparities

- Nearly half of all U.S. births are financed by Medicaid⁴
- Compared with women with private insurance at delivery, Medicaid-enrolled pregnant women are more likely to:⁵
 - ✓ Be Black—i.e., the women who are most impacted by the crisis
 - ✓ Have had a prior preterm birth and/or a low birthweight baby and to experience certain chronic conditions (e.g., diabetes)—that put them at higher risk for poor outcomes

Medicaid Agencies Can Shape Policies and Drive Broader Change

- States can set Medicaid policies related to eligibility for coverage, the duration of coverage, the benefits women receive, and the delivery system through which they receive care
- In partnership with sister agencies, Medicaid agencies can use their purchasing power and “bully pulpit” to drive broad policy and cultural change

Medicaid Strategy Levers to Improve Maternal Health



In some cases, the Medicaid agency will be responsible for implementing these policies. In other cases, the Medicaid agency can lead collaboration with other state agencies. ***In all cases, state consultation with the communities and consumers affected by these policies is essential to improving outcomes.***



Coverage and Enrollment

Snapshot of Coverage and Enrollment Strategies



Strategies for Discussion Today

1.1 Expand Medicaid

1.2 Continue Medicaid/CHIP Coverage for 12 Months Postpartum

1.3 Cover Otherwise Ineligible Immigrant Women through CHIP

2.1 Expedite Enrollment for Pregnant and Postpartum Women

Strategy 1.1 Expand Medicaid

Medicaid expansion is the most effective strategy to ensure access to comprehensive care for women with incomes up to 138% FPL

Preconception, Prenatal, and Postpartum Care Needs:

**Postpartum/
Ongoing Care:** assess and treat health-related complications; support healthy practices and chronic condition management; contraceptive care if desired

Before Pregnancy: prevent, detect, and treat conditions that impact maternal health outcomes; contraceptive care if desired

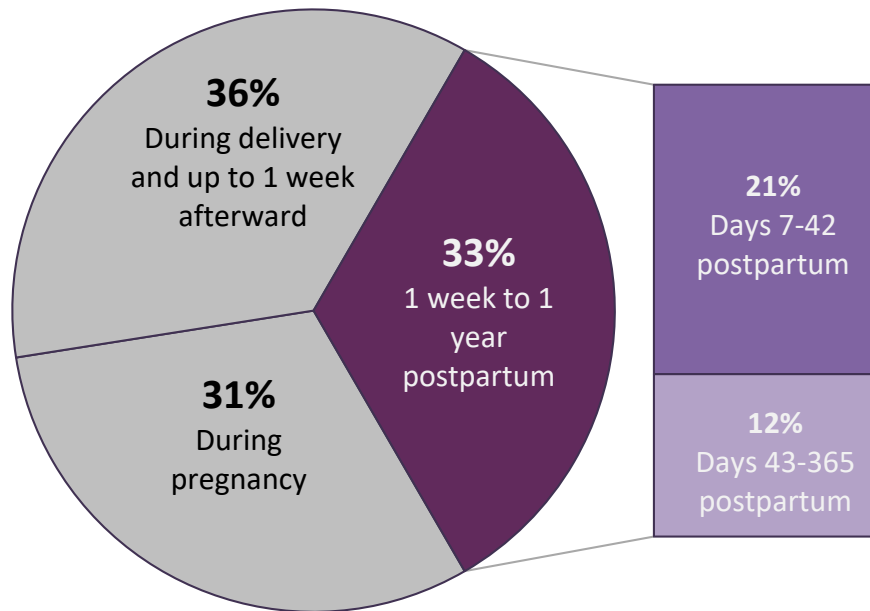
During Pregnancy: prenatal care; reproductive health planning

In a recent National Center for Health Statistics study, Medicaid expansion was associated with 1.6 fewer maternal deaths per 100,000 women compared with states that did not expand Medicaid⁶

Strategy 1.2 Continue Medicaid/CHIP Coverage for 12 Months Postpartum

Nearly 1 in 3 maternal deaths occur more than 7 days postpartum – and postpartum women in expansion and non-expansion states experience gaps in coverage⁷

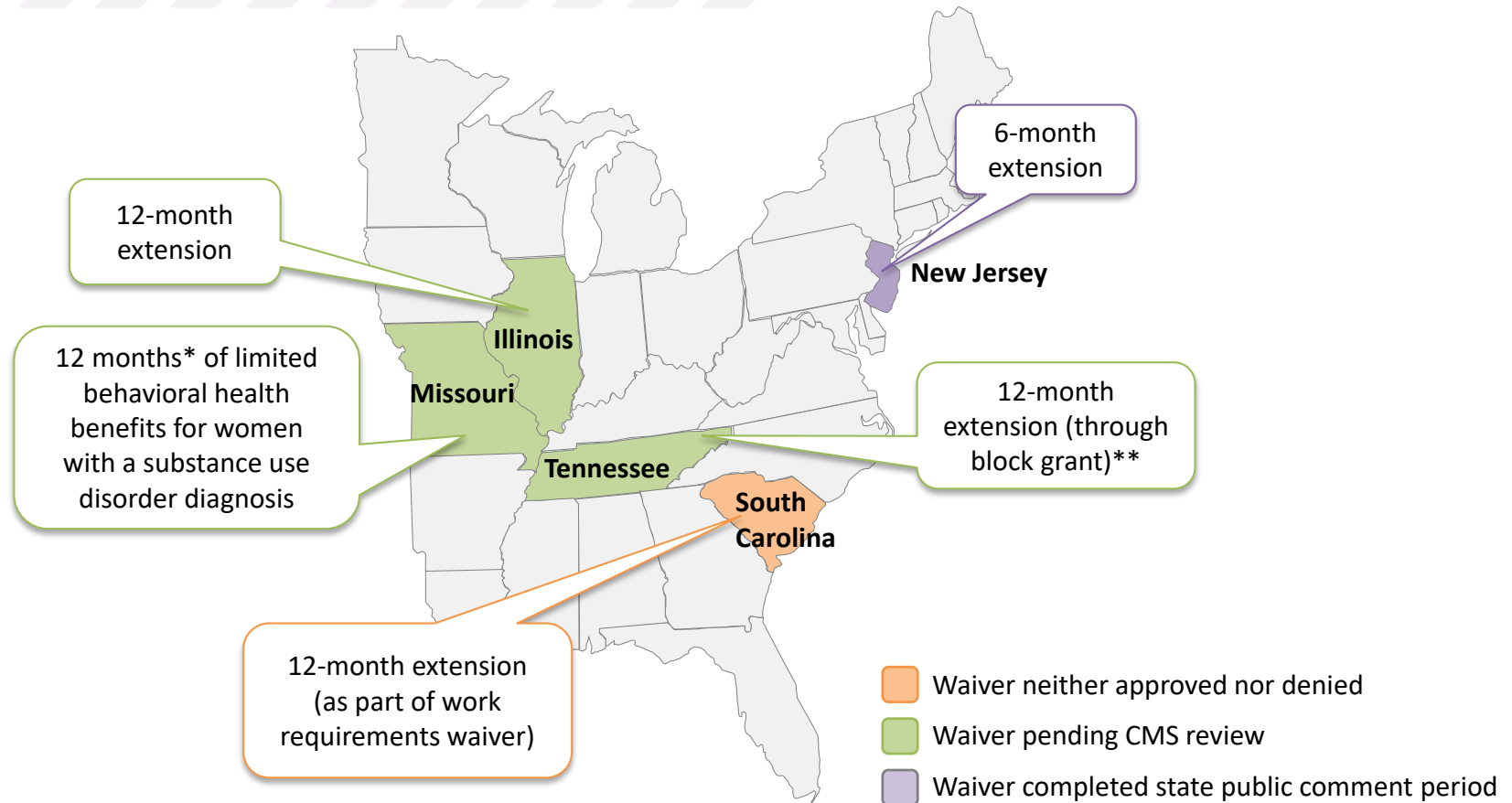
U.S. Pregnancy-Related Deaths By Time of Death
2011-2015 (CDC)⁸



Nationally, 17% of women experience uninsurance between delivery and 3-6 months postpartum⁹

- *In expansion states:* 12%
- *In nonexpansion states:* 25%

States Seek 1115 Waivers to Extend Postpartum Coverage



**Begins upon termination of full coverage (occurs at the end of the month in which the 60th postpartum day falls). All other state waivers would replace the current 60 days of postpartum coverage with the proposed coverage duration (6 months or 12 months).*

***A postpartum extension is noted as a priority for program innovation under the block grant waiver; Tennessee has not yet submitted a waiver to request authority to extend postpartum coverage.*

Strategy 1.3 Improve Coverage for Otherwise Ineligible Immigrant Women through CHIP

ICHIA Option*/ CHIPRA §214

- State plan option to cover prenatal, labor and delivery, and postpartum care services for lawfully-residing immigrant pregnant women during their first five years in the U.S.
- As of January 2019, 25 states have adopted the ICHIA option

“Unborn Child” Option

- State plan option to cover prenatal care, labor and delivery and *limited* postpartum care services for undocumented immigrant pregnant women
- As of January 2019, 15 states have adopted the unborn child option

States are eligible to received the enhanced CHIP matching rate under these options

**This option under CHIPRA is referred to as ICHIA because it incorporates earlier legislation called the Immigrant Children’s Health Improvement Act*



State Example: Illinois Strategies to Improve Postpartum Coverage

Waiver Request to Extend Medicaid Coverage through 12 Months Postpartum¹¹

- 12 months continuous eligibility for Medicaid/CHIP-enrolled postpartum women* (at or below 213% FPL).
- Extending coverage beyond the current 60 days was a Maternal Mortality Review Committee recommendation.
 - ✓ In Illinois, 51% of pregnancy-associated deaths and 79% of deaths due to suicide or unintentional drug overdose occur 61-364 days postpartum.
 - ✓ Non-Hispanic black women are six times more likely to die of a pregnancy-related condition than non-Hispanic white women.
- State law to extend coverage with January 2020 effective date.
 - 1115 Waiver seeks federal match to implement it.
- Waiver goals include averting preventable postpartum deaths by increasing continuity of care and improving outcomes through MCO performance management

CHIP Health Services Initiative (HSI):¹²

- Finances postpartum care services for Legal Permanent Residents (LPRs) subject to 5-year waiting period *and* undocumented women through 60 days postpartum
 - 1115 waiver proposal extends coverage through 12 months postpartum for LPRs in 5-year waiting period using HSI
- HSIs are subject to a 10% of CHIP allotment cap

*Current waiver proposal does not include undocumented women



Benefits



Benefit Strategies

3.1 Cover and Integrate Doula Services

3.2 Cover and Expand Access to Home Visiting Services

3.3 Cover Enhanced Dental Services for Pregnant and Postpartum Women

Strategy 3.1 Cover and Integrate Doula Services

- **Two of the leading causes of maternal death:**¹³
 - ★ Missed/delayed diagnoses
 - ★ Not recognizing warning signs of complications
- **Doulas empower women to communicate their needs/perceptions by providing non-clinical emotional, physical and informational support before, during and after birth**¹⁴
- **Doula care is linked to better outcomes**^{15,16,17}
 - ✓ Fewer low birthweight babies
 - ✓ Fewer preterm births
 - ✓ Fewer cesarean sections
- **States are increasingly covering doula services in Medicaid**
 - ✓ **Oregon and Minnesota:**^{18,19} Cover doula services in state plan
 - ✓ **New York:**²⁰ launched state-funded pilot initiative (see next slide)
 - ✓ **New Jersey and Virginia:**^{21,22} in 2019, announced developing initiatives to cover doula services in Medicaid



State Example: New York's Doula Pilot Program²³

Program Snapshot:

- Launched in one county (Erie) in March 2019
- Plans to expand to King's County next
- State-only funds for now
- FFS Medicaid and MCOs cover:
 - ✓ Up to four prenatal care visits
 - ✓ Labor and delivery support
 - ✓ Up to four postpartum care visits

Key Considerations:

- Engaging community of doulas, who were not previously Medicaid providers
- Soliciting hospital and MCO participation and collaboration
- Establishing provider certification requirements
- Determining reimbursement
- Supporting doulas in navigating new environment: MCO contracting, billing and reimbursement on per-service basis
- Engaging and educating patients about doula care

Strategy 3.2 Cover and Expand Access to Home Visiting

State Medicaid agencies can build upon/cover services provided by public health-funded home visiting programs or establish Medicaid home visiting programs

State Example	Medicaid Authority	Services
Colorado^{*24} (Nurse Family Partnership)	State plan services: <ul style="list-style-type: none"> Targeted Case Management 	<ul style="list-style-type: none"> ✓ Regular home visits for 1st time parents with incomes below 200% until child is 2 y/o ✓ Case management services
Michigan²⁵ (Maternal Infant Health Program)	State plan services: <ul style="list-style-type: none"> “Extended services” for pregnant women EPSDT 	<ul style="list-style-type: none"> ✓ Case management services ✓ Professional visits by registered nurses, social workers, other licensed professionals
Maryland^{26,27} (Home Visiting Pilot Program: Nurse Family Partnership and Healthy Families America)	Section 1115 demonstration waiver	<ul style="list-style-type: none"> ✓ Prenatal and postpartum services

**Program is also funded by the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)*



Models of Care

Models of Care Strategies

4.1 Leverage Medicaid to Promote a Statewide Maternity Levels of Care Framework

4.2 Implement Enhanced Prenatal Care Models

4.3 Integrate Maternal Behavioral Health Screenings in Prenatal, Postpartum, and Pediatric Care Services

Strategy 4.3 Integrate Maternal Behavioral Health Screenings in Prenatal, Postpartum, and Pediatric Care Services

Across models of care, access to behavioral health services is critical to improving outcomes

- For low-income mothers, rates of depressive symptoms are reported to be between 40% and 65%²⁸
- Medicaid-enrolled mothers are more likely to need substance use disorder treatment than pregnant women with all other forms of coverage²⁹

Approaches to improving behavioral health screenings and treatment access

Strategy	State Example(s)
Require or incentivize providers to use standardized screening tools	<ul style="list-style-type: none">▪ New Jersey requires providers to complete a standardized screening tool during the first prenatal visit (includes assessment of mental health, substance use, and social risk factors)³⁰▪ North Carolina pays Pregnancy Medical Home providers \$50 for completing its high-risk screening tool at the initial prenatal visit³¹
Cover postpartum screenings as part of the EPSDT well-child visit	<ul style="list-style-type: none">▪ Illinois covers perinatal depression screenings when an approved screening tool is used; if the postpartum depression screening occurs during a well-child visit, it may be billed under the child's Medicaid ID³²
Increase base payment rates for behavioral health services	<ul style="list-style-type: none">▪ The majority of states increased base payment rates to improve access to substance use disorder treatment in response to the ongoing opioid crisis³³



Quality Improvement

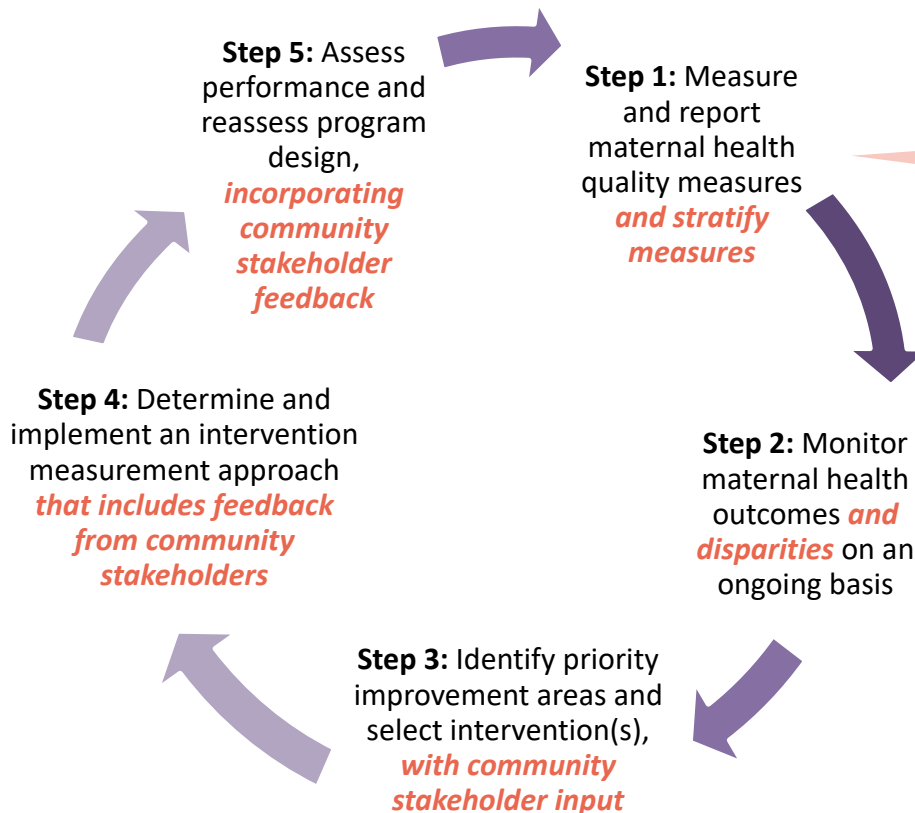
Quality Improvement Strategies

5.1 Prioritize Engagement in Statewide Maternal Health Quality Improvement Initiatives

5.2 Measure, Report, and Assess Maternal Care Measures for Outcomes Disparities

Strategy 5.2 Measure, Report, and Assess Maternal Care Measures for Outcomes Disparities

Armed with data regarding outcomes disparities, state Medicaid agencies are better positioned to target outreach and solutions



- A clear starting point is the **CMS Core Set of Maternal and Perinatal Health Measures**³⁴
- States can build upon this data by:
 - ✓ **Customizing measures** (e.g., new HEDIS measures for perinatal and postpartum depression screening)
 - ✓ **Stratifying measures to identify disparities** (e.g., race and ethnicity, geographical data)

Discussion

The slides and a recording of the webinar and the companion issue brief will be available at www.shvs.org after the webinar

Thank You

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